review of any determination made by FCIC may be brought.

Environmental Evaluation

This action is not expected to have a significant economic impact on the quality of the human environment, health, and safety. Therefore, neither an Environmental Assessment nor an Environmental Impact Statement is needed.

Background

FCIC proposes to amend 7 CFR part 457 (Common Crop Insurance Regulations) by revising 7 CFR 457.162 (Nursery Crop Insurance Provisions) and 7 CFR 457.163 (Nursery Peak Inventory Endorsement). The provisions will be effective for the 2008 and succeeding crop years. The changes to the provisions for insuring nursery production are as follows:

Section 457.162 Nursery Crop Insurance Provisions

Section 1—FCIC is proposing to amend the definition of ''liners'' to remove language that specifies an established root system for a liner plant must reach the sides of the container and to remove language regarding the firm root ball. This change is necessary because liners are also known as starter plants, which often have not developed a root system that reaches the sides of the containers. While no one commented on this when the provisions regarding liners were first proposed, RMA has since received complaints from the nursery industry advising the cited language is agronomically incorrect and could adversely affect insurability of liners. By the time most liners have reached the point where the root system reaches the side of the container, they have already been sold or are ready to be sold. Therefore, without this change, most liners would be uninsurable while they are in the nursery and during the period of greatest risk of loss.

7 CFR 457.163 Nursery Peak Inventory Endorsement

Section 7—FCIC is proposing to amend provisions to clarify that the maximum increase in the amount of insurance under the Nursery Peak Inventory Endorsement is limited to twice the amount of insurance under the Nursery Crop Insurance Provisions. As stated, the peak amount of insurance is limited to 200 percent of the basic unit value. This means that if a basic unit value is $50 and the producer had 50 percent coverage, the amount of insurance would be $25. Under the current language, the producer could increase the peak amount of insurance to $100 (200 percent of $50 basic unit value), which is a four fold increase in liability. FCIC never intended to allow more than a two fold increase in liability because to allow a larger increase could encourage insureds to carry minimum year-round coverage and maximize coverage under Peak Inventory Endorsement during high-risk periods. This could adversely affect indemnities paid and amount of premium owed to maintain an actuarially sound program.

List of Subjects in 7 CFR Part 457

Crop insurance, Nursery, Reporting and recordkeeping requirements.

Accordingly, as set forth in the preamble, the Federal Crop Insurance Corporation proposes to amend 7 CFR part 457 the Common Crop Insurance Regulations effective for the 2008 and succeeding crop years, to read as follows:

PART 457—COMMON CROP INSURANCE REGULATIONS

1. The authority citation for 7 CFR part 457 continues to read as follows:

Authority: 7 U.S.C. 1506(l), 1506(p).

2. Revise the definition of ''liners'' in paragraph 1 of § 457.162 to read as follows:

§ 457.162 Nursery crop insurance provisions.

* * * * *

1. Definitions.

* * * * *

Liners. Plants produced in standard nursery containers that are equal to or greater than 1 inch in diameter (including trays containing 200 or fewer individual cells, unless specifically provided by the Special Provisions) but less than 3 inches in diameter at the widest point of the container or cell interior, have an established root system, and meet all other conditions specified in the Special Provisions.

* * * * *

3. Amend paragraph 7 of § 457.163 to read as follows:

§ 457.163 Nursery peak inventory endorsement.

* * * * *

7. Liability Limit.

The peak amount of insurance is limited to 200 percent of the amount of insurance established under the Nursery Crop Insurance Provisions.

Signed in Washington, DC, on August 21, 2006.

Eldon Gould,

Manager, Federal Crop Insurance Corporation.

[FR Doc. E6–14364 Filed 8–31–06; 8:45 am]

BILLING CODE 3410–08–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 422

[CMS–4121–P]

RIN 0938–AO54

Medicare Program; Prohibition of Midyear Benefit Enhancements for Medicare Advantage Organizations Offering Plans in Calendar Year 2007 and Subsequent Calendar Years

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would prohibit Medicare Advantage (MAs) organizations, including organizations offering employer/union group health plans (EGHPs) (that is, plans that enroll both beneficiaries and employer/union members (plans open to general enrollment) and plans that are not open to general enrollment), from making midyear changes to nondrug benefits, premiums, and cost-sharing submitted in their approved bids for a given contract year. Programs of all-inclusive care for elderly (PACE) would not be subject to the provisions of this proposed rule and could continue to offer enhanced benefits as specified in our guidance for PACE plans.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 31, 2006.

ADDRESSES: In commenting, please refer to file code CMS–4121–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail*. You may mail written comments (one original and two copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4121–P, P.O. Box 1850, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4121–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–4121–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking*. Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

FOR FURTHER INFORMATION CONTACT: Christopher McClintick (410) 786–4682.

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) made important changes to the Medicare+Choice (M+C) program under Part C of Medicare and renamed the program Medicare Advantage (MA). In the August 3, 2004 **Federal Register** (69 FR 46866), we published a proposed rule that set forth the provisions that would implement Title II of the MMA. Subsequently, in the January 28, 2005 **Federal Register** (70 FR 4588), we published a final rule to implement our proposals. The changes that MMA made to the MA program—

- Provided for regional plans that have made private plan options available to many more beneficiaries, especially those in rural areas.
- Expanded the number and type of plans provided for, so that more beneficiaries can choose from Health Maintenance Organizations (HMOs), Preferred Provider Organization (PPO) plans, and Private Fee-for-Service (FFS) plans, and further authorized Medical Savings Account (MSA) plans, if available where the beneficiary lives.
- Enriched the range of benefit choices available to enrollees including improved prescription drug benefits under the new Medicare Part D.
- Provided incentives to contracting health plans to create specialized plans to coordinate and manage care in ways that comprehensively serve those with complex and disabling diseases and conditions.
- Used competition among MA plans to improve service, improve benefits, invest in preventive care, and hold costs down in ways that attract enrollees.
- Enhanced and stabilized payments to contracting organizations, improved program design, introduced new flexibility for plans, and reduced impediments to plan participation.
- Advanced the goal of improving quality and increasing efficiency in the overall health care system.

Over time, organizations offering MA plans will be under continued competitive pressure to improve benefits, reduce premiums and cost sharing, and improve networks and services in order to gain or retain enrollees. In addition, we expect MA organizations offering plans to use integrated health plan approaches such as disease prevention, disease management, and other care coordination techniques. In doing so, integrated plans that combine the original Parts A and B of Medicare and the new Part D drug benefit and apply these innovative techniques must pass on savings that may result from these care coordination techniques to the enrollee through reduced premiums or additional benefits.

In conjunction with the new Part D drug benefit required under Title I of MMA, which was finalized in the January 28, 2005 **Federal Register** (70 FR 4194), changes made in the MMA to the MA program are intended to bring about broad-based improvements to the Medicare program's benefit structure, including improved prescription drug coverage under the MA program. Organizations offering local and regional coordinated care MA plans must offer at least one plan with the Medicare prescription drug benefit or an actuarially equivalent drug benefit.

Beginning in 2006, payments for local and regional MA plans are based on amounts submitted in bids rather than on a statutory formula. MA organizations offering health plans submit an annual aggregate bid amount for each MA plan. An aggregate plan bid is based upon the MA organization's determination of expected costs in the plan's service area for the national average beneficiary for providing nondrug benefits (that is, original Medicare (Part A and Part B) benefits), Part D basic prescription drugs, and supplemental benefits (including reductions in cost sharing). For an MA plan's coverage of original Medicare benefits, our payment to an MA organization depends on the relationship of the plan's basic A/B bid to a ''benchmark'' amount determined through a statutory formula (for regional

plans the benchmark is based in part on bids submitted in the region). For a plan with a basic A/B bid below its benchmark, we pay the MA organization the basic A/B bid amount, adjusted by the individual enrollee's risk factor, plus the rebate amount. (The rebate is 75 percent of the difference between the plan bid and benchmark, and is used to provide mandatory supplemental benefits or reductions in Part B or Part D premiums. The government retains the other 25 percent.) For a plan with a bid equal to or above its benchmark, we pay the MA organization the plan benchmark, adjusted by the individual enrollee's risk factor. The MA organization is required to charge any difference between its bid and the benchmark in the form of a premium.

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption ''Provisions of the Proposed Regulations'' at the beginning of your comments.]

In the August 3, 2004 **Federal Register** (69 FR 46866), we proposed to prohibit MA organizations from offering midyear benefit enhancements (MYBEs) that is, enhanced benefits or reductions in premiums or cost-sharing amounts not specified in the approved bid for the calendar year (CY) in question. In commenting on the August 3, 2004 proposed rule, several commenters objected to our proposal to eliminate MYBEs. These commenters believed that we could allow MYBEs without affecting the integrity of the bidding process.

In the January 28, 2005 final rule (70 FR 4639), we noted that under the previous M+C program, we permitted M+C organizations to offer new plans midyear and to offer MYBEs to existing benefit packages. In the final rule (70 FR 4640), we also noted that MYBEs ''* * * would be a *de facto* adjustment to the benefit packages from which bids were submitted earlier in the year.'' In our related final rule (published January 28, 2005 (70 FR 4301)) implementing the Medicare prescription drug benefit (Part D regulations), we stated that MYBEs ''* * * would be *de facto* acknowledgement that the revenue requirements submitted by the plan were overstated.'' We also note that the Part D regulations do not permit MYBEs under any circumstances. Although we acknowledged that MYBEs could threaten the integrity of the bidding process, in response to comments on the August 3, 2004 proposed rule, we decided to permit them on an interim basis under limited circumstances. Therefore, in the January 28, 2005 final rule (70 FR 4640), we stated that we would permit MYBEs to nondrug benefits only under the following circumstances:

- An MYBE can be effective no earlier than July 1 of the contract year, and no later than September 1 of the contract year;
- MA organizations cannot submit MYBE applications later than July 31 of the contract year; and
- Twenty-five percent of the value of the MYBE will be retained by the government.

If the MYBE meets the circumstances described above, the requesting MA organization—

- Must ''submit, for each plan or segment, a revised bid and any supporting documentation related to the enhancement, including information on where the revenue requirements were overstated in the annual June bid submission;'' and
- Would be subject to CMS consideration of ''whether there is a current year MYBE request when analyzing a plan's bid for the following year.''

In the final rule, we exempted the program of all-inclusive care for the elderly (PACE) plans and employer/union group health plans (EGHPs) that are not open to general enrollment (that is, both the ''800 series'' employer-only plans and group plans where we contract directly with the employer/union offering an MA product, now referred to collectively as employer/union-only group waiver plans (EGWPs)) from the new restrictions on MYBEs. As stated in the final rule (70 FR 4640), we exempted PACE plans in order to promote coordination of Part C and Part D benefits with the benefits PACE plans are required to offer under section 1894 of the Act. In the January 28, 2005 final rule, we also noted that we did not believe that the competitive nature of the bidding process was affected if benefit packages for PACE organizations or EGHPs not open to general enrollment were adjusted midyear in accordance with our guidance.

In addition, we stated (70 FR 4640) that we considered this policy to be an interim policy ''for the initial years'' of the competitive bidding system, and indicated we would ''review whether there is a continuing need for this policy.'' We have reevaluated our MYBE policy over the course of the first contract year of the new bidding process, and believe that there is no longer a need for this interim policy. We note that this policy was intended to assist MA organizations during the initial phase of the new bidding process, while ensuring that beneficiaries have a choice of plans. We believe the focus should now be solely on ensuring the integrity of the bidding process established by statute so that there will be an even playing field for organizations and, as a result, a choice of health plan options for beneficiaries.

We believe that continuing the current MYBE policy would threaten the integrity of the competitive bidding process established by the MMA. Under the bidding process, MA organizations compete with one another by submitting plan bids that specify the revenue requirements for offering the various components of their health plans. We believe that permitting MYBEs could undermine the integrity of the competitive bidding process as MA organizations, knowing that they could alter their benefit packages after the bidding process was complete, could misrepresent their actual costs to provide benefits (overbid) and noncompetitively revise their benefit packages later in the year. More specifically, we believe that MYBEs offered in July or September of the contract year would be offered in a way primarily to attract individuals in their initial coverage election period (ICEP). We believe that such individuals are very attractive to MA organizations because of their relatively low utilization (they are new to the program and tend to be healthier) and because of their numbers (nationally, over 100,000 individuals per month ''age-in'' to Medicare). Additionally, we estimate that organizations planning on revising their bids through MYBEs could overbid by approximately 2–3 percent in order to distinguish themselves from other plans later in the year and attract ICEP beneficiaries.

Using the MYBE process in this manner would undermine the competitive nature of the bidding process in two ways. First, it would encourage overbidding, and second, it would penalize MA organizations that do not attempt to ''game the system'' and which instead offer a bid that more accurately represents their costs to offer benefits over the full course of a contract year.

While it is too early in the MA program to quantify the percentage of plans that we believe would use MYBEs to bolster plans later in the year, we will gather data and incorporate our findings in our response to public comment, as appropriate. We believe, however, that allowing MYBEs in 2006 has served its purpose to ease the transition to the new, more competitive MA program. We are equally convinced that our

primary goal going forward must be to ensure, as mandated by statute, that plans compete on an even playing field and that beneficiaries will gain in terms of cost, plan choices, and generosity of benefits. We believe we can help achieve this goal only if MYBEs are not permitted in subsequent years.

Furthermore with respect to MYBEs, we do not believe that nondrug benefits should be treated differently than Part D benefits. Similarly, with respect to all EGHPs including EGWPs, we believe that the integrity of the competitive bidding process overrides any possible program benefit from MYBEs. Therefore beginning with CY 2007, we are proposing that MA organizations, including all organizations offering EGHPs, would not be permitted to make any midyear changes in benefits, premiums, or cost-sharing, even under the circumstances in which these types of changes were permitted in CY 2006. This includes EGHPs that enroll both beneficiaries and employer/union members (in other words plans open to general enrollment) and plans not open to general enrollment. We note that programs of all-inclusive care for the elderly (PACE) would be able to continue to offer MYBEs in accordance with our guidance for PACE plans.

III. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption ''Regulatory Impact Statement'' at the beginning of your comments.]

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule. However, we are requesting comments regarding the possible impact of our proposal to prohibit MYBEs.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. The MA program, by having both regional and local plans, provides an opportunity for health insurance entities of all types and most sizes (but probably not below the ''small'' insurance entity cutoff level defined by the SBA ($6 million), which is lower than appears viable for a comprehensive, risk-bearing insurance plan) to participate. Therefore, we are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This rule will have no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 5, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 12, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–7394 Filed 8–31–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

49 CFR Parts 171, 172, 173, 174, and 178

[Docket No. PHMSA–06–25736 (HM–231)]

RIN 2137–AD89

Hazardous Material; Miscellaneous Packaging Amendments

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: In this NPRM, PHMSA is proposing to make miscellaneous amendments to the Hazardous Materials Regulations (HMR) based on changes to packaging requirements in the United Nations Recommendations on the Transport of Dangerous Goods, petitions for rulemaking received in accordance with requirements specified in 49 CFR